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ABSTRACT

A shortage of home care paraprofessionals in Ohio is causing concern about the quality and continuity of care. Worker turnover is high, ranging from 30-70 percent. Most paraprofessionals share several traits: middle-aged women; single, with dependents; sole breadwinners in their households; wage earners of less than $11,000 per year; part-time workers; and high school graduates or less. Several reasons account for the labor shortage: low wages; lack of benefits, career advancement, recognition, and full-time hours; inadequate training and supervision; burnout; transportation problems; and worker isolation. Trends affecting the home health industry include the following: the increasing elderly population; decreasing availability of family caregivers; escalating health care costs; the AIDS epidemic; and limits to nursing home admissions. Standardized training and certification would increase continuity and quality of care, establish minimum criteria for workers, provide for consistency and uniformity of workers' training and skill levels, and provide credentials. Action is being taken through public policy changes, coordinated funding and policies, state-mandated wage and benefit levels, agency coalitions, work life improvements, and worker-owned agencies. (18 references) (NLA)

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Who Will Deliver the Care?

A Study of the Availability of Home Care Paraprofessionals in Ohio

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Executive Summary

We are saying that, without the paraprofessional component, we do not have home care.

— Nola Aalberts
National Home Caring Council

Home care is truly an industry whose time has come. With skyrocketing hospital costs prompting earlier discharges and regulatory agencies limiting the availability of new nursing home beds, the home care industry is scrambling to fill in the gaps in the health care system. Even more important than meeting current demands of the health care industry, long-term care in the home is consistently proven through research to be preferred by most people over institutional care (Kane and Kane, 1987).

The majority of home care services are not medically intensive. Most do not require a licensed nurse or therapist. Instead, the services most in demand are nonmedical, supportive care such as homemaking and personal care. Seventy percent of the in-home services provided under Ohio's PASSPORT program are delivered by paraprofessionals (Ohio Department of Aging, 1988). Clearly, the most critical personnel need in the home health care industry is for paraprofessionals.

Currently in Ohio, as in the nation, there is a crisis in home care. The industry is experiencing a paraprofessional shortage. Turnover rates is some areas are reported to be as high as 80-90 percent. In a recent survey of Ohio's home health agencies, 72 percent of respondents said that their agencies were experiencing moderate to severe shortages of home health aides, homemakers, personal care attendants, companions and chore workers.

It should come as no great surprise that home care paraprofessionals are choosing other employment alternatives. Poverty level wages, inconsistent training and the lack of upward mobility are just a few of the factors forcing paraprofessionals out of home care. In national, state and local research, low wages and lack of benefits were consistently cited as the top two factors leading to paraprofessional turnover. Home care workers are expected to function in a much less predictable environment,

take on more responsibility and work more autonomously than their peers in hospitals and nursing homes. In exchange, they are offered fewer hours, lower pay and virtually no benefits.

The plight of home care paraprofessionals adversely affects elderly and disabled home care clients, as well as workers. Clients are placed on waiting lists for weeks because of the lack of available workers. High turnover rates make the delivery of continuous, high quality home care services virtually impossible. As one author said, "Both home health care paraprofessionals and clients suffer and are unjustly served within our current system (Surpin, 1988)."

There are major shortcomings in the current home health care system which contribute to the paraprofessional shortage and complicate efforts to resolve it. These shortcomings include funding mechanisms and policies which are fragmented and inefficient. There is no coordination between third-party funding sources (Medicaid, Medicare, Title XX and Title III) in paraprofessionals titles, service definitions, training and job performance standards and pay rates. In addition, third-party payers supply 70 percent of home care revenues. Unless these third-party payers significantly increase their reimbursement rates for paraprofessional services, wage and benefit increases will not be possible.

Finally, home care paraprofessional training is inconsistent and often inadequate. There is no way to monitor the training and work records of home care paraprofessionals across the state. More than 75 percent of Ohio's home health agencies recently surveyed favored a statewide, standardized training and certification program for paraprofessionals, saying that this would contribute to the continuity and quality of client care in the home. Survey respondents also said that the status of home care paraprofessionals would be enhanced through this process.

Action is needed in all of these areas immediately. The home care paraprofessional shortage is not a problem that can be put on the back burner. The issue at hand is the dwindling supply of workers who are the primary paid caregivers for our most frail and vulnerable citizens.

The Human Resources Committee, made up of experts in the home care industry in Ohio, has studied these issues and made recommendations to the Governor for ensuring a stable home care paraprofessional work force from now to the year 2000. The Committee's recommendations are listed at the end of this document.

I. State of the Art

Currently in Ohio, efforts are being made to expand the availability of home and community-based long-term care services. While policymakers are working to establish a comprehensive, responsive home and community-based service delivery system, they are concurrently faced with a growing shortage of trained paraprofessional home care workers. These workers are an integral part of the home health care system. They provide the services which are most often needed by elderly and disabled clients in their homes. For many, home care paraprofessional services can mean the difference between living in their own homes and being institutionalized.

A recent report on the development of community-based long-term care systems in six states said, "The services needed most often are non-medical, in-home supports such as homemaker and personal care ... ," and " ... nonmedical supportive services form the core of state long-term care programs ... " (Justice, 1988). In Ohio, home care paraprofessionals deliver 70 percent of PASSPORT's in-home services (Ohio Department of Aging, 1988). Without an adequate supply of qualified homemakers, home health aides and other home care paraprofessionals, even the most skillfully planned home and community-based service delivery system cannot function.

For this reason, the Ohio Department of Aging recently completed a study of the availability of home care paraprofessionals in Ohio. Research was conducted on national, state and local levels. This paper will describe this research effort, as well as it's findings. The problem will be defined, contributing factors will be discussed and possible solutions will be outlined based on the current literature. The process for collecting Ohio data, including surveys of three relevant groups, will be described, and results will be presented.

The final section of this paper includes the Human Resource Committee's recommendations to the Governor regarding what steps should be taken in Ohio to provide an adequate supply of home care paraprofessionals from now through the year 2000.

Problem Definition

In this report, "home care paraprofessional" is used to describe all non-licensed personnel who are paid to provide in-home services to the elderly and disabled. These workers include, but are not limited to, homemakers, home health aides, personal care attendants, chore workers and companions.

"Shortage" is used in discussing the problems and issues related to home care paraprofessionals. Based on informal information received from home care providers in Ohio, the assumption was made that a shortage of home care paraprofessionals exists in this state. Webster defines "shortage" as " ... a deficiency in the quantity or amount needed or expected." In the course of this study, it was discovered that "shortage" has more than one dimension as it applies to home care paraprofessionals in Ohio. In this study, "home care paraprofessional shortage" can mean one or all of the following:

- A deficiency in the quantity of people to fill home care paraprofessional job positions;

- A deficiency in the quantity of trained and/or experienced home care workers;

- A deficiency in the quantity of people willing to accept the work of home care paraprofessionals (versus often more attractive offers by fast food chains and retail establishments); and

- A deficiency in the quantity of funding available for programs which provide home care paraprofessional services.

The problem, as it exists in Ohio, involves all of these dimensions in differing levels of severity, depending on geographic location, relative economic status and population density. So, as the home care paraprofessional shortage in Ohio is discussed throughout this paper, it is important to keep in mind the problem's multidimensional nature.

Scope of the Shortage

According to recent national research, there are home care paraprofessional shortages nationwide. Worker turnover within this group is particularly high. Turnover rates for home care paraprofessionals are reported to range from 30-70 percent across agencies and are estimated at 60-70 percent industry-wide (Feldman, 1988). A 1988 article in *Caring* magazine says that " ... paraprofessionals experience a 60 percent turnover within one year and 80-90 percent within two years" (Surpin, 1988). With such extremely high turnover rates among the most frequently utilized workers in home care, there is cause for concern about the quality and continuity of care clients receive in their homes.

A 1987 report by the National Institute on Aging further describes the national shortage, stating that, " ... the supply and training of home health aides, as well as personal careworkers and housekeepers, are very uneven and are generally seriously deficient" (p. 105). This report goes on to say that all areas of the country are experiencing "inadequate or marginally adequate" supplies of homemakers and hospice services (p. 107).

The National Association for Home Care recently surveyed 2,197 member agencies. Health care agencies from all 50 states, as well as the District of Columbia and Puerto Rico, were represented in the sample. Forty-eight percent of survey respondents stated that they were having difficulty recruiting and retaining homemaker/home health aides. The NAHC Survey respondents expressed frustration at not being able to attract workers because of Medicare cost caps which prevent them from raising home care paraprofessionals' wages. Respondents also complained of losing home care workers to fast food chains that offer more attractive wages and work environments (Jones, 1988).

Profile of the Home Care Paraprofessional

To better understand the dynamics of this shortage and related issues, it is necessary to understand who the paraprofessionals are. Dr. Penny Feldman, with the Harvard School of Public Health, recently completed an extensive study of home care paraprofessionals entitled

The Ford Home Care Study (sponsored by the Ford Foundation). This study, as well as a 1988 study by The Older Women's League and the AFSCME Union, surveyed groups of paraprofessional home care workers. Common characteristics of home care paraprofessionals were cited in both reports. According to these research efforts, most home care paraprofessionals share several traits:

- middle-aged women;
- single, with dependents;
- sole breadwinners in their households;
- wage earners of less than $11,000 per year;
- part-time workers; and
- high school graduates or less.

Home care paraprofessionals are a part of the secondary labor market. Labor market segmentation, or the dual labor market perspective, as discussed by Minkler and Stone, refers to the fact that in a Capitalist society, two separate groups emerge in the labor market. The primary sector includes jobs with relatively high salaries, good fringe benefits and job security. The secondary labor market includes jobs with low wages, few benefits, poor working conditions and minimal job security (1988, p. 355).

Feldman also discusses labor market segmentation as it relates to the home care industry. She reports that women are disproportionately overrepresented in secondary sector jobs, and that home care paraprofessionals clearly are relegated to this disadvantaged sector. Further, Feldman reports that black women tend to be even more highly concentrated in these jobs and more disadvantaged (such as lower pay and fewer benefits) than white women in the same types of jobs (1988).

In a 1988 article in *The Gray Panther Network*, Bernardy verifies this in the following statement:

> *Home health care is an industry that confirms that sexism and racism are shamefully alive and well in America today. Offering low paying, dead-end jobs, the work is left primarily to poor women, women of color. In New York, for example, 99 percent of the [home care] workers are women, 96 of every 100 are of color and nearly half are immigrants.*

The current literature clearly gives testimony to the fact that the home health industry is in trouble. There is a nationwide shortage of the most essential workers in the home health field. The majority of home care paraprofessionals are themselves members of minority populations and are as vulnerable as the clients they serve. Many home health administrators and professionals have failed to recognize the valuable role these workers played until recently, when the once endless supply of home care workers began to run out.

Issues Contributing to the Shortage

How and why did the home care paraprofessional shortage happen? It did not occur in a vacuum. It is the product of a number of complex, interrelated issues. The causative factors include those directly related to workers and their work environment, as well as numerous societal and health care trends.

Factors Related to Workers and the Work Environment

The current literature contains several articles that address the problems of recruitment, retention and high turnover rates among home care paraprofessionals. Canalis (1987), Surpin (1988), and Lombardi (1988) identified some major contributing factors associated with recruitment, retention and turnover of paraprofessionals. These factors include:

- low wages;
- lack of benefits;
- lack of full-time hours;
- inadequate training;
- lack of career advancement;
- inadequate supervision;
- burnout due to job stress;
- lack of recognition;
- transportation problems; and
- worker isolation.

While this list is not exhaustive and not necessarily in priority order, low wages and lack of benefits consistently rank as the top two factors involved in paraprofessional turnover in the literature.

Information From Other States

Twenty-three state units on aging, selected on a nonrandom basis, were contacted by telephone. Community-based long-term care managers in these states were asked whether their state was experiencing a home care paraprofessional shortage and, if so, whether there were any formal efforts being made to alleviate the shortage. All of the states expressed some level of awareness of difficulties in their state with recruiting and retaining home careparaprofessionals. In the state of Iowa, for example, the supply of home health aides was reported to have dropped to the number that was available ten years ago. A home care provider in this state reported that aides now have to work longer hours and clients receive less hours of service because of the shortage.

Over half of the states contacted have some type of formal effort in progress to deal with the training, recruitment, retention, wages, certification and/or working conditions of home care paraprofessionals. These efforts range from the most minimal attempts at preparing to meet the Omnibus Reconciliation Act of 1987 requirements for home health aide training, to much more comprehensive endeavors such as the extensive research report prepared by the New York State Labor-Health Industry Task Force on Health Personnel (1989). Through the review of national research, as well as the informal telephone survey process, it became clear that the home care paraprofessional shortage has touched virtually every part of the United States.

II. Trends

In addition to those factors directly related to workers and the work environment, several major health care and labor market trends impact the home health industry and ultimately increase the demand for home care paraprofessionals and complicate efforts to alleviate worker shortages. Such trends include:

• The increasing elderly population, especially the 85-plus age group;

• The decreasing availability of family caregivers to provide care for their aging relatives at home (partially because of increasing numbers of women entering the paid work force);

• Escalating health care costs which have prompted a search for less expensive ways to deliver health care services;

• The AIDS epidemic, which has given rise to increased interest in home care as a more humane and less expensive option for care; and

• Nursing home care is becoming less available as an option for elder care because of high costs and limits on additional nursing home beds imposed by state regulatory agencies (Feldman, 1988).

Labor Market Trends

• The home care paraprofessional shortage is emerging at the same time that the entry level labor force is shrinking. This is especially disturbing when one considers the likelihood that most of these workers will probably take jobs in fast food or retail sales. Wages, benefits and working conditions will undoubtedly be more attractive in these occupations than in home care if current trends continue.

• Unemployment, particularly in urban areas, is relatively low, which engenders fierce competition from factories, retail and fast food industries for relatively few workers. As if this weren't enough, the home health industry, which is seeing a substantial increase in the number of proprietary

agencies, is becoming more competitive every day. In an informal poll taken of Ohio PASSPORT providers, agencies were reluctant to share their recruiting and retention strategies for paraprofessionals with an Ohio Department of Aging representative. They did not want their competition to find out what worked for them, in fear that other agencies would take prospective employees from them.

This intense competition forces home health agencies to increase their focus on cost containment. Unfortunately, this is often reflected in paraprofessionals' wages and benefits. One author says that the low wages and inadequate benefits that home care paraprofessionals receive " ... function in effect as a subsidy for maintaining the extremely low cost of home care services" (Surpin, 1988, p. 26). Bernardy concurs by saying " ... the weight of keeping home health care cost at an acceptable level has fallen on hundreds of thousands of downtrodden home health care aides and homemakers" (1988, p. 3).

These and other factors work together to make the pathway to resolving the paraprofessional shortage look somewhat like a labyrinth. The problem extends well beyond the home health industry's boundaries. Clearly, there is no simple solution to this problem.

Fragmented Funding and Policies

Not only are home care paraprofessionals forced to accept substandard wages and benefits, but they are also expected to function in the midst of what may be termed an occupational identity crisis. This refers to the fragmented funding and policies which govern the delivery of home care services. Funding sources for paraprofessional home care services include: Medicare, Medicaid, Title XX and Title III of the Older Americans Act. Different state and/or county agencies may administer services under each of these funding sources. In spite of the fact that the services provided by each of these programs are essentially the same, different funders and administrative agencies have different titles for workers, different standards and definitions of services and different standards for worker training. Therefore, wages and benefits offered are inconsistent, standards for training and work performance vary greatly, supervision and monitoring requirements differ between programs and worker titles could literally vary from one client to the next. The fragmented federal

financing mechanisms have distorted and complicated what are basic but vital services for aging adults and have made the working conditions for those who deliver these services chaotic.

Inadequate Reimbursement Rates

As long as the medical/institutional bias prevails, it will be extremely difficult for the home care industry to recruit and retain paraprofessionals. This is because about 70 percent of home care revenues come from third-party payers, such as Medicare and Medicaid (Feldman, 1988). To date, third-party payers have been unwilling to significantly increase the rates at which they reimburse agencies for paraprofessional services. This makes it difficult for agencies to provide home care paraprofessionals with an attractive wage and benefits.

The Medical Model

The health care delivery system is ruled by the Biomedical Acute Care Model (Harrington, 1987, p. 21). This model judges only acute, institutionally-based medical services as valuable and sees home and community-based services, such as those delivered by paraprofessionals, as having little value. Publicly funded health care financing programs tend to ignore the need for more social, versus medical, services for the elderly and continue to reflect the bias toward acute and institutional care. Most of Medicare dollars are spent on acute care in the hospital. Most of Medicaid funding for long-term care goes into nursing home care.

Projected Need

If action is not taken to resolve the home care paraprofessional shortage, the future outlook for home care for the elderly and disabled is not bright. Projections of present and future need for these workers is mind-boggling. According to the U.S. Department of Labor, the number of home health aide positions will increase by 80 percent from 1986-2000, rating this among the fastest growing occupations. This will mean approximately 111,000 new home health aide positions nationwide (1988).

This DOL projection does not include homemakers, chore workers or companions. Projections have not been made for these workers.

The National Association for Home Care estimates the potential need for homemakers and home health aides based on experiences in European countries. According to the NAHC, at least 500,000 homemakers and home health aides are currently needed to provide one aide for every 100 persons 65 years of age and older, and one aide for every 1,000 younger persons. This is said to be twice the number of these workers available in the current work force (National Institute on Aging, 1987).

III. Ohio's Outlook

How does Ohio compare with the national picture in its supply of home care paraprofessionals? According to information from the Ohio Bureau of Employment Services, between 1986 and 1995 home health aide positions are expected to increase at a rate of 5 percent per year, a 45 percent increase over nine years. This percentage is significant when compared to the 1 percent average annual percent of change for all of Ohio's industries during that same time period. Home health aides are listed as fourth out of the 20 fastest growing occupations in Ohio (1988). Home health aide jobs are the only home care paraprofessional positions formally tracked by OBES at this time. OBES counts numbers of jobs, not workers. An accurate total of home care paraprofessional workers in Ohio is not currently available.

Ohio Data Collection

Three statewide surveys were administered to the key groups involved with home care paraprofessional issues.* A telephone survey was administered to representatives from each of the 12 Area Agencies on Aging. Written surveys were completed by the directors of 161 member agencies of the Ohio Council of Home Health Agencies and by 173 paraprofessional members of the Home Care Paraprofessional Association of Ohio.

Each of the groups surveyed offered a unique perspective on paraprofessional issues. Based on the survey results, the following conclusions may be drawn as to availability of home care paraprofessionals in Ohio:

Survey Findings

• There is a significant shortage of home care paraprofessionals in Ohio. **Sixty-seven percent** of the AAA respondents and **72 percent** of the agency directors surveyed characterized the **shortage** as either **"moderate" or "severe."**

• The two factors most frequently cited by all three groups as contributing to the shortage were **low wages** and **inadequate benefits**.

• **Sixty-seven percent** of the home care paraprofessionals in Ohio work **part-time**.

• **Full-time** home care paraprofessionals (who make up only 33 percent of the workforce) receive the **greatest proportion** of health care **benefits**.

• The **highest paid** home care paraprofessionals in Ohio are **home health aides**. These workers earn an average of $4.99 per hour. If they are fortunate enough to be among the 33 percent who work full-time, home health aides may earn a gross annual salary of around $10,000, taking home only about $133 per week.

• **Training** of home care paraprofessionals is often **inconsistent** and varies widely. Required training programs range from 0-190 hours. The majority of home care paraprofessional training occurs in home health agencies and on the job.

Proposed Remedies

• **Statewide, standardized training** and **certification** of home care paraprofessionals is needed and highly favored throughout the state. Sixty-seven percent of the AAA directors and 75.2 percent of the home health agency directors said they favored such a program for Ohio. Reasons given included:

- to increase **continuity** and **quality** of **care**;

- to establish **minimum criteria** for workers entering the home care field;

- to provide for **consistency** and **uniformity** of workers' **training** and **skill** levels;

- to increase home care **clients' safety** and **peace of mind**; and

- to provide **credentials** and **credibility** for home care paraprofessionals.

• Action is being taken throughout Ohio to alleviate paraprofessional shortages. These steps include:

- increasing **wages**;

- offering **transportation reimbursement**;

- implementing paid, in-house **training** programs;

- offering **continuing education**; and

- offering paid **health benefits**, **sick leave** and **vacation time**.

* *Complete survey results, including a description of the survey process and an analysis of the survey data, is available by contacting the Ohio Department of Aging.*

IV. Options for Resolving the Home Care Paraprofessional Shortage

Both national and Ohio research confirm the presence of a critical home care paraprofessional shortage. The contributing factors and related issues are extremely complex and multifaceted. While it is clear that no single solution will restore the rapidly diminishing supply of home care paraprofessionals, the future is not entirely bleak. Currently, measures are being taken in public and private sectors to resolve the home care paraprofessional crisis. Some of these measures are summarized below.

Public Policy Changes

There is evidence emerging that policymakers are beginning to see that acute and institutional care are not the only games in town. Third-party payers are beginning to cover more paraprofessional home care services. The newly added respite care benefit in the Medicare Catastrophic Act of 1988 is an example of this. The challenge, once third-party payers start to reimburse for paraprofessional services, will be to convince them to continuously reimburse at rates that will support an ongoing, trained labor force.

Coordinated Funding and Policies

Even the current system of fragmented public funding and policies is not beyond hope. There are parts of the country where methods have been developed to coordinate the various funding sources for paraprofessional home care services into a common pool. An example of this is a group of local funders in Tulsa, Oklahoma, who developed a model that coordinated the funding and assessment of paraprofessional home care services. The Tulsa model included a set of uniform definitions of services, job titles and standards of care, as well as a plan for monitoring and evaluating quality of care. Federal, state and local funders of paraprofessional home care services were integrated in this model (Mumma, 1987).

State Mandated Wage and Benefit Levels

Efforts are being made in several states to address the poverty level wages and inadequate benefits of home care paraprofessionals. For example, Washington and Massachusetts are attempting to alleviate paraprofessional shortages by setting mandatory wage and benefit levels. In Washington, a legislative mandate was written, assigning a minimum hourly wage of $5.15 for home care paraprofessionals in publicly funded programs (Washington State Aging and Adult Services, 1988). In Massachusetts, the rate setting commission for the state established a rate of $7.41 per hour for a wage and benefit package for homemaker/home health aides in state funded programs (Aalberts, 1988).

Agency Coalitions

Outside the public arena, the outlook may also be brighter. With competition from the retail and fast food industries as an ongoing challenge, home health agencies are uniting in the battle for workers. In Pasadena, California, a coalition of proprietary and non-profit home health agencies formed under the umbrella of an independent case management organization called Senior Care Network. The purpose of this alliance was to cooperatively deal with worker shortages. These agencies share not only their recruiting and retention strategies, but also their paraprofessionals.

In Ohio, a similar agency coalition was formed in the northwestern part of the state. The Northwest Ohio Home Health Council consists of representatives of home health agencies, social service agencies, educators of home health personnel and any other groups interested in quality home health care. The council originally formed in March 1988 to address the issue of quality training for home care professionals. The council's major goals for 1989 include expanding their membership, organizing their internal operations, preparing a generic brochure for member organizations to distribute and conducting a home nurse assistant recognition event during Home Health Week later this year.

Work Life Improvements

Many states are employing various measures to improve the wages, benefits, training and overall status of home care paraprofessionals. The Ford Home Care Project is the most significant effort to date to address these work life factors that impact on workers and their environment. In addition to worker surveys, this study ran demonstration projects in cities across the country. These projects provided evidence that turnover among home care paraprofessionals can be significantly reduced when improvements are made in wage and benefit levels, training and support, status, opportunities for advancement and hours of work. Workers in the demonstration projects were 11-14 percent more likely to remain on the job after one year than the control group (Feldman, 1988).

Worker-owned Agencies

The concept of worker-owned home care agencies appears to be an excellent means of enhancing the pay, benefits and status of home care paraprofessionals. Cooperative Home Care Associates, in the South Bronx, New York, is 70 percent worker-owned. This agency is committed to providing higher wages and benefits and full-time hours for as many of their employees as possible. The workers may buy into the company after a three-month probationary period with an initial investment of $50 and weekly payroll deductions of $3.50. Higher wages, benefits and full-time work are available because of the high volume of service the agency provides. CHCA has also initiated a career ladder and includes paraprofessionals in all agency management decisions.

V. Recommendations

Next Steps for Ohio

From now through the year 2000, Ohio's long-term care system will require an ongoing supply of well-qualified and trained home care paraprofessionals. Given that home care paraprofessionals provide the greatest share of in-home services for the elderly and disabled, it is important to examine the current working conditions and status of these workers in Ohio and implement improvements where needed.

The Human Resources Committee makes the following recommendations governing the treatment of home care paraprofessionals from now to the year 2000. In addition, several implementation steps to carry out these recommendations are presented.

Wages, Benefits and Working Conditions

1. State agencies employing home care paraprofessionals will serve as role models for other employers of home care paraprofessionals by fully accepting these workers as highly valued members of the home health care team and affording them equal status. As such, home care paraprofessionals will be entitled to:

a. a fair and equitable hourly wage and regularly scheduled pay increases;

b. affordable benefits, including health insurance;

c. additional compensation for weekend, holiday and overtime work;

d. reimbursement for work-related travel costs and travel time;

e. a guaranteed minimum number of work hours per week;

f. sick leave and vacation time, based on hours of service;

g. programs that provide access to flexibility in hours and assignments;

h. readily available physical equipment and supplies necessary for clients' care; and

i. support groups (supervisory and peer groups) to alleviate worker isolation and preclude burnout.

Training

2. A standardized training program will be in place that includes:

a. minimum standards for entry into training;

b. in-service education, administered at the work site, to promote career advancement and for home care paraprofessionals to upgrade skills; and

c. competency testing (written and practical demonstration tests).

3. Universities and colleges will be encouraged to develop programs in basic personnel management for home care paraprofessionals.

4. Programs that sensitize paraprofessionals and management of direct services to the cultural and economic diversity of the client and the paraprofessional will be encouraged and supported.

5. Job training and retraining programs will be encouraged to include the home care paraprofessional in their placement goals.

Implementation

6. An interagency work group will be initiated by the Governor's Office to standardize titles, definitions and standards used for home care paraprofessionals.

7. Development of a standardized career progression system (entry, experienced and senior levels) for paraprofessionals, in conjunction with OBRA mandates, will be encouraged and supported.

8. A statewide public relations and recruitment will be initiated that emphasizes the positive image of home care paraprofessionals and includes an annual recognition day for them.

9. A statewide educational campaign will be developed to raise the awareness of funding bodies, organizations and businesses, legislators and educational institutions regarding basic issues that affect home care paraprofessionals.

10. A centralized, computerized clearinghouse or registry will be instigated to register and monitor the pool of paraprofessionals. This registry will include the following:

a. a listing of people who have been screened, including a personal security check;

b. a listing of people who have had formal homemaker and/or home health aide training; and

c. a centralized system for agencies to screen applicants.

11. To test the effectiveness of these recommendations, demonstration projects and model programs will be implemented and evaluated.

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